

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

03-031

2. STATE

Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

August 13, 2003

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR 438

7. FEDERAL BUDGET IMPACT

a. FFY 2003 \$ 0

b. FFY 2004 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Pages 1 (List of Attachments), 9, 11, 45(a), 45(b), 54, 55, 71, 77, 78a, 22 and 41

Attachment 2.2-A, pages 10 and 10a

Attachment 4.30, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Pages 1, 9, 11, 45(a), 45(b), 54, 55, 71, 77, 78a, 22 and 41

Attachment 2.2-A, Pages 10 and 10a

Attachment 4.30, Page 2

Attachment 2.1-A (removed)

10. SUBJECT OF AMENDMENT

CMS-issued preprint pages

11. GOVERNOR'S REVIEW (Check One)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

Melanie Bella

13. TYPED NAME

Melanie Bella

14. TITLE

Assistant Secretary, OMPP

15. DATE SUBMITTED

9/30/03

16. RETURN TO

Melanie Bella, Asst. Secretary
Office of Medicaid Policy & Planning
402 W Washington, Room W382
Indianapolis, IN 46204
ATTN: Tracy Brunner, Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

12/23/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

08/13/03

20. SIGNATURE OF REGIONAL OFFICIAL

Chapman

21. TYPED NAME

22. TITLE

23. REMARKS

LIST OF ATTACHMENTS

<u>No.</u>	<u>Title of Attachments</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
* Supplement 1 -	Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
* Supplement 2 -	Definitions of Blindness and Disability (Territories only)
* Supplement 3 -	Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
* Supplement 1 -	Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
* Supplement 2 -	Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
* Supplement 3 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 4 -	Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

TN # 03-031
 Supersedes
 TN # 91-16

Approval Date 8/13/03Effective Date 8/13/03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Indiana

Citation 42 CFR 431.12(b) AT-78-90	1.4 State Medical Care Advisory Committee	
	There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.	
42 CFR 438.104	<u>X</u> The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.	

TN # 03-031
Supersedes
TN # 75-1

Approval Date DEC 11 2003 Effective Date 8/13/03

INDIANA MEDICAID STATE PLAN

11

Revision: HCFA-PM- (MB)

State/Territory: Indiana

Citation

- | | | |
|--|------------|--|
| 42 CFR
435.914
1902(a)(34)
of the Act | 2.1(b) (1) | Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in <u>Attachment 2.6-A</u> . |
| 1902(e)(8) and
1905(a) of the
Act | (2) | For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. <u>Attachment 2.6-A</u> specifies the requirements for Determination of eligibility for this group. |
| 1902(a)(47) and | _____(3) | Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. <u>Attachment 2.6-A</u> specifies the requirements for Determination of eligibility for this group. |

TN # 03-031
Supersedes
TN # 94-030

Approval Date DEC 22 2003

Effective Date 8/13/03

Revision: HCFA-PM-91-
1991

(BPD)

OMB No.: 0938-

State: Indiana

Citation 3.1(a)(9)

Amount, Duration, and Scope of Services: EPSDT
Services (continued)

42 CFR 441.60

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The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240
and 440.250

(a)(10) Comparability of Services

1902(a) and 1902
(a)(10), 1902(a)(52),
1903(v), 1915(g),
1925(b)(4), and 1932
of the Act

Except for those items or services for which sections
1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the
Act, 42 CFR 440.250, and section 245A of the
Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

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** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

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Supersedes

TN # 91-017

Approval Date DEC 8 1993

Effective Date 8/13/03

New: HCFA-PM-99-3
JUNE 1999

State: Indiana

Citation

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-031
Supersedes
TN # 99-007

Approval Date DEC 23 2003

Effective Date 8/13/03

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Indiana

Citation

1902 (a)(58)

1902(w) 4.13 (e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

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statutory or recognized by the
courts) concerning advance
directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
 - (a) Hospitals at the time an individual is admitted as an inpatient.
 - (b) Nursing facilities when the individual is admitted as a resident.
 - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
 - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
 - (e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

Not applicable. No State law
Or court decision exist regarding
advance directives.

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AUGUST 1991

OMB No.: 0938-

State/Territory: Indiana

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51

through 447.58 (a)

Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) (b)
of the Act

Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[] Age 19

[] Age 20

[] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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State/Territory: Indiana

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

☐ Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

☒ Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act,
P.L. 99-272,
(Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

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